



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

Division of Licensing & Certification

DDA/ResHab Certification - Statement of Deficiencies

<b>Agency:</b>	Community Connections, Inc.	<b>Region(s):</b>	3 & 4
<b>Agency Type:</b>	ResHab	<b>Survey Dates:</b>	28 March – 29 March, 21017
<b>Certificate(s):</b>	RHA-233 RHA-367	<b>Certificate(s) Granted:</b>	<input type="checkbox"/> 6 - Month Provisional <input type="checkbox"/> 1 - Year Full <input checked="" type="checkbox"/> 3 - Year Full

Rule Reference/Text	Findings	Agency's Plan of Correction (Please refer to the Statement of Deficiencies cover letter for guidance)	Date to be Corrected (mm/dd/yyyy)
No deficiencies were cited over the course of the survey.	No deficiencies were cited during the course of the survey. The provider is not required to submit a Plan of Correction to the Department.		

<b>Agency Representative &amp; Title:</b> No signature required.  <i>* By entering my name and title, I agree to implement this plan of correction as stated above.</i>	<b>Date Submitted:</b> n/a
<b>Department Representative &amp; Title:</b> Sandi Frelly, Medical Program Specialist  <i>* By entering my name and title, I approve of this plan of correction as it is written on the date identified.</i>	<b>Date Approved:</b> 3/30/2017